

ROBBINS (H. A.)

al

SYPHILIS OF THE VITAL ORGANS.

By HENRY ALFRED ROBBINS, M. D.

OF WASHINGTON, D. C.

EX-PRES. WASHINGTON SOCIETY OF MICROSCOPISTS; LATELY CLINICAL PROFESSOR OF DERMATOLOGY AND SYPHILOLOGY, MEDICAL DEPARTMENT OF THE UNIVERSITY OF GEORGETOWN; DIRECTOR OF THE DERMATOLOGICAL CLINIC AT THE SOUTH WASHINGTON FREE DISPENSARY; AUTHOR OF "LUES VENEREA," "ORGANIC SYPHILIS," "UNMERITED SYPHILIS," AND "3D ACT OF THE DRAMA OF SYPHILIS."

presented by the author



CEREBRAL SYPHILIS.*

By HENRY ALFRED ROBBINS, M. D.,
OF WASHINGTON, D. C.,

EX-PRESIDENT OF THE MICROSCOPICAL SOCIETY OF WASHINGTON, D. C. ; LATELY CLINICAL
PROFESSOR OF DERMATOLOGY AND SYPHILOLOGY, UNIVERSITY OF GEORGE-
TOWN ; DIRECTOR OF THE DERMATOLOGICAL CLINIC AT THE
SOUTH WASHINGTON FREE DISPENSARY.

[Reprinted from VIRGINIA MEDICAL MONTHLY, May, 1895.]

On the 12th day of April, 1893, I delivered a lecture to a class of medical students on the subject of internal syphilis, which was published in the *Virginia Medical Monthly* of July, 1893. I called attention to the fact that syphilis was not mentioned as a cause of cerebral diseases by many authors of publications on diseases of the nervous system. The possibility of said disease being a cause of any mental trouble was not mentioned by the renowned Dr. Abercrombie, of Edinburgh, in his work on "*Diseases of the Brain and Spinal Cord*." This was the popular text-book, and was the authority not very many years ago. Trousseau never mentioned cerebral syphilis, attributing nervous symptoms to cranial periostitis. In fact, Sir Astley Cooper, the most distinguished student of John Hunter, and the great pathologist himself, taught that the vital organs were never attacked by syphilis.

It is only within the past few years that, owing to the discoveries made in the pathological rooms, the ravages made by syphilis have been comprehended. It was in 1869 that

* Read before the Medical Society of the District of Columbia on February 27th, 1895.



Professor Rudolph Virchow, in his anatomical laboratory at Berlin, cleared up the nature of syphiloma of the brain and its membranes. Several years prior to this, 1863, Dr. Sam'l Wilks, of Guy's Hospital, took the lead in pointing out the injurious effects of syphilis in the internal organs. Modern research, he then said, has been mainly in the direction of discovering a wider influence for the venereal virus, and tends to show that the internal organs may be affected equally with the external. As Dr. Wilks expresses it: "Syphilis, in its ultimate form, is capable of affecting every organ of the body; the internal may become equally as obnoxious to the effects of the virus as the external. Many obscure and intractable organic disorders are cases of visceral syphilis, and it cannot be too forcibly impressed upon the young practitioner that syphilis may affect not only the cranium, but the brain within it, or the nerves; not only the muscles of the limbs and tongue, but the heart; not only the pharynx, but the œsophagus; not only the larynx, but the trachia, bronchi, and lungs; also the liver, spleen, and other viscera." (*Guy's Hospital Report*, Vol. IX, 1863.)

In 1874, Professor Heubner described certain lesions as characteristic of syphilis. He described fibroid indurations, and the syphilitic tumors, known as gumma, and certain changes in the arteries. "In the cerebral arteries, the changes produce opacity and marked thickening of the vessel, with considerable diminution in its calibre. It is this diminution of the lumen of the vessel which is especially characteristic. When transverse sections of the vessel are examined microscopically, the principal change is seen to be situated in the inner coat. This coat is considerably thickened by a cellular growth. The growth which is limited internally by the endothelium of the vessel, and externally by the membrana fenestrata, closely resembles ordinary granulation tissue, consisting of numerous small round and spindle-shaped cells. The tissue appears gradually to undergo partial development into an imperfectly fibrillated

structure. In addition to this change in the intima, the outer coat is abnormally vascular and infiltrated with small cells, and this cellular infiltration usually invades the muscular layer. The result of these changes in the inner coat is to diminish very considerably the lumen of the vessel; and the consequent interference with the circulation frequently leads to coagulation of the blood (thrombosis) and cerebral softening."

Associated with Dr. Samuel Wilks at Guy's Hospital was the late most accomplished pathologist, Dr. Walter Moxon. Together they wrote their great work on pathology, which is in daily use by every anatomist. For several months, I had the honor of being an assistant to Dr. Moxon in the *post-mortem* room of Guy's Hospital. The changes which occur in the brain in this dread disease were thus described by him: "Syphilis attacks the surface of the brain and the membranes; it attacks them in limited spots, and spreads slowly. The morbid changes are, on the one hand, adhesion of the membranes to each other and to the surface of the brain by means of an adventitious material of firm consistence and yellow color, which may be called lymph, but is harder, tougher, and more opaque. This exudation may be found at any part of the surface; it invades and destroys the grey matter, interferes with the supply of blood, and when it occupies the membranes at the base of the brain surrounds and involves the nerves in the inter-cranial part of their course. In the examination of the brain after death (over 1,000), I have been surprised to find in how small a number this disease appeared to originate in the under layer of the periosteum of the endo-cranium. I think this, perhaps, may be accounted for by the fact that when a gumma of the inner table of the skull does arise, the clinical features, evidenced by pain, etc., are so marked (for these manifestations usually occur with the existence of external gummata) that remedial measures are adopted early, and thus promotes absorption before the membranes of the brain become involved."

In 1886, Dr. Wilks, in a lecture on "Medical Treatment," said: "I think I can show you how an improved treatment has come about, not by the discovery of new drugs, but by a better knowledge of the nature of disease and by clinical observation. Thousands of persons are now cured of epilepsy, paralysis, and various other nerve disorders by means of iodide of potassium, and why? Because syphilis was found to attack the brain and internal organs, when a more extended and closer observation of morbid structures was begun to be made in the *post-mortem* room. Let me most emphatically dwell upon this point, that an improved treatment, saving thousands of lives annually, arose, not from the discovery of a new drug, but from work in the dead-house."

Verily, the more you make a study of syphilis, the more you will consider it a Proteus, capable of assuming hundreds of different forms.

Alfred Fournier, in his book, "*La Syphilis du Cerveau*," published in Paris in 1879, makes us acquainted with the more common, as well as the more usual forms, which brain syphilis is apt to assume at the bedside. Fournier describes six different forms as follows: The cephalalgia, the congestive, the convulsive or epileptiform, the aphasic, the mental, and the paralytic. Before Fournier gave this admirable and accurate description, we were groping in the dark, as I am acquainted with no other work which even attempts a description, except that in later years of Dr. Thomas Stretch Dowse, and that you will find only on the shelves of a medical library or of a neurologist.

As physicians, you will be called in during syphilitic coma or hemiplegia. Althaus, of London, says: "A knowledge of syphilitic coma is of great practical importance, inasmuch as it requires an entirely different treatment from other forms of coma, and an incorrect diagnosis is in such a case likely to seal the fate of the patient."

Lack of time will prevent my referring to the different

forms of coma, or where there is a loss of consciousness or motion, and where you will have to make a diagnosis as to the cause—such as syncope, asphyxia, epilepsy, puerperal eclampsia, uræmic coma, alcoholic stupor, the comatose stages of eruptive fevers, certain forms of gout and rheumatism, and the poisonous effects of opium, belladonna, lead, etc.

It is a maxim in whist that, “when in doubt, lead trumps.” Remember what Dr. Thomas S. Dowse says of iodide of potassium: “In nervous diseases, the physician commands this drug to carry out his object, and it does it, too, as surely, as completely, and effectually as the surgeon’s knife in excising a tumor.”

There seems to be some question as to whom is due the credit of first recommending the use of iodide of potassium in the treatment of syphilis. Mr. James R. Lane stated, in a lecture published in the *Lancet* June 23rd, 1877, on the syphilitic affections of the viscera: “I do not think it is sufficiently remembered that we owe to a physician, the late Dr. Robert Williams, of St. Thomas Hospital, the introduction of the iodide of potassium in the treatment of syphilis, without doubt the greatest improvement which has been effected in this country.”

At the meeting of the British Medical Association held in Dublin, August 3rd, 1887, Dr. C. R. Drysdale, of London, said: “A statue should be erected to Dr. Wallace, of Dublin, who was the discoverer of the virtues of iodide of potassium in syphilis. Before his day, syphilis was a terrible disease.”

Coma is the forerunner to paralysis, which is the most frequent result of the syphilitic poison upon the nervous system. That grand old Quaker, Jonathan Hutchinson, gives the following advice: “So frequently is syphilis a cause of paralysis that in all cases where it happens without evident cause, and in which syphilitic antecedents are even possible, it is advisable to try the effects of specific treat-

ment. Undoubtedly we often, by such means, get a clue to the real nature of many an obscure affection of the nervous system."

Heubner gives five types of symptoms resulting from syphilitic brain lesions:

I. Psychological disturbances, with epilepsy, incomplete paralysis (seldom of the cranial nerves), and a final comatose condition, usually of short duration.

II. Genuine apoplectic attacks, with succeeding hemiplegia, in connection with peculiar somnolent conditions, occurring in often repeated episodes; frequently phenomena of unilateral irritation, and generally at the same time paralysees of the cerebral nerves.

III. Course of the cerebral disease similar to paralytic dementia.

IV. Psychological disturbances without complete epileptic convulsions, associated with palsy of the basal nerves, and often with partial hemiplegia.

V. Paraplegia associated with ocular or other symptoms, indicative of lesions at the base of the brain.

The mental symptoms are not definite as regards any special feature. It is the want of coincidence in the mental symptoms, as in the paralysees, that strongly characterizes syphilitic diseases of the brain, as Professor Heubner describes it, "The half and half incomplete nature of the severe symptoms, the impairment of the consciousness without its entire destruction, the loss of voluntary activity without the complete abolition of voluntary impulse, the half awake and half dreamy condition of the patient, are strong peculiarities of syphilis."

Not infrequently among the first of the mental symptoms is the lack of æsthetic feeling. Sometimes from the purest they become the most obscene.

Dr. Grundy reports the case of a most respectable and highly connected young lady, whose friends had noticed in her a growing tendency to "*double entendres*," to slight

smuttiness in conversation, and they were at a loss to account for this. He suspected syphilis, but was not for a long time listened to. Finally, after getting the patient on specific treatment, these morbid peculiarities disappeared.

Dr. A. H. Newth, in the *Lancet* of October, 1892, publishes an extremely interesting article on syphilitic insanity, in which he refers to two cases reported by Dr. Clouston. One a clergyman who, twelve years after syphilitic insanity, conducted himself most obscenely towards the female members of his congregation. The other was a medical man, who, though otherwise able to conduct his practice well, misconducted himself towards young girls. Both of these had to be placed under treatment in an asylum. In the *Virginia Medical Monthly* of June, 1892, in an article called the "Third Act of the Drama of Syphilis," I reported two cases of insanity caused by syphilis. Dr. Savage, of London, states that syphilitic insanity is rare, and says that some acute cases follow the delirium, which may follow with the case. Many lunatics exhibit venereal diseases contracted while insane. He also states insanity may follow the onset of secondary symptoms of the more severe type, thus with optic neuritis, with ulcerations about the face, or it may appear with the onset of local paralysis of the third or other cranial nerves. It may occur with the neuralgia or sleeplessness of syphilis. The disfigurement may cause insanity. There are cases where syphilis has acted as a moral cause, and has set up a form of hyperchondriasis. Epilepsy may occur with or without insanity. The epilepsy may be the chief symptom, or only a sign of widely spread disease, or it may be a symptom of general paralysis, or of locomotor ataxy. Dr. Savage reports a group of cases, in which progressive weak-mindedness follows constitutional syphilis. It may be preceded by some motor symptoms, by either the ocular motor trouble, a monoplegia, or hemiplegia, in one by aphasia, and in another with other motor troubles. There was another group in which sensory trouble, some temporary

loss of vision, or taste, or hearing, some aphasia, or some temporary giddiness may be the first symptom, which is followed by progressive degeneration, which is not of the same kind, and not to be grouped with the general paralysis of the insane depending upon syphilis. He classified these cases as organic dementia of syphilitic origin.

Dr. Spitzka reports an unusual case of mental syphilitic manifestations occurring in an actor. This patient had abolition of both knee-jerks. His disease was at times controlled by treatment, and then recurred. He had had, in the course of one day, fifty or sixty attacks of a peculiar kind of "*petit mal*," in which he lost consciousness, while coming upon the stage oftentimes, but so briefly that he could recollect himself. In one case, where he had to cross a foot bridge, he had an attack in the course of passing over, but he went on as if nothing had happened, the "*petit mal*" losing its character as a loss of consciousness, and becoming replaced by a peculiar sensory disturbance. He found that accompanied by the prodromal feeling all the faces of the audience were exactly the same. This sensation passed like an electric flash. These peculiarities continued, but at longer intervals.

At the meeting of the British Medical Association, 1887, held at Dublin, a paper was read on Syphilitic Aphasia by Dr. Drysdale, of London. The author said he had seen a case of syphilitic aphasia as early as 1861, in Dr. Gubler's ward, at the Hospital Beaujean at Paris. That year Dr. Broca wrote his work on aphemia, a term altered to aphasia by Professor Trousseau. At that time it was not, as now, known that syphilis could cause aphasia by narrowing the calibre of the vessels of the brain, or by formation of gummy tumors. In all cases of syphilitic aphasia which he had treated there had been right hemiplegia. The first of these he had under his care was that of a gentleman who, in 1851, contracted syphilis. He was a most intellectual man, and a celebrated professional. This gentleman had suffered for

many years with fits of vertigo, which yielded well to iodide of potassium, and suddenly, in 1871, or twenty years after the initial lesion, he had an attack of right hemiplegia and aphasia. His general health continued pretty good, but the symptoms of complete aphasia and hemiplegia remain quite unaffected by treatment. He died in 1886, after being aphasic for fifteen years. Another distinguished literary man contracted syphilis in 1870, and had symptoms resembling locomotor ataxia three years subsequently, with mental disturbances. In 1876 he was attacked with right hemiplegia, and was speechless for a time. Remedies were of great service to him at that date. However, in 1887, being in Ireland on a visit, he was carried off by a cerebral attack.

In the *Virginia Medical Monthly* for October, 1894, in an article called "Unmerited, or Non-Venereal Syphilis," I reported the case of Professor Von Zeissel, who died of cerebral syphilis, many years after acquiring the disease, from a wound received in opening a syphilitic bubo.

At a recent meeting of the New York Neurological Society, Dr. Nammack presented two cases of syphiloma of the brain. The first occurred in a cloth examiner, aged thirty-four, who, six weeks after contracting a chancre, suddenly became unconscious, and had no recollection of what transpired during the succeeding forty days. Following this there was right-sided hemiplegia, which confined the man to bed for three months. As soon as the initial lesion was discovered, the patient was put on specific treatment, and this was vigorously continued for a long time. About six weeks after the treatment was discontinued the patient developed severe occipital headache and bi-hemianopsia, with ataxia and exaggeration of the knee-jerks. Under specific treatment these symptoms almost entirely disappeared. It is believed that the lesion was probably a gumma situated in the substance of the optic chiasm.

The second patient was a man, forty-four years old, who complained of dizziness, bilateral occipital headache, tin-

nitus, absolute deafness of the left ear and diplopia. He also had the characteristic cerebellar gait. The history of syphilis in this case was rather obscure, but under specific treatment the man's symptoms almost entirely disappeared. The diagnosis was gumma in the cerebellar region.

At the meeting of the American Neurological Association, held in New York city, 1894, Dr. Charles L. Dana reported 182 cases of apoplexy, of which 100 were non-fatal, and 82 fatal. Dr. Dana stated: "Taking hemiplegia as a whole, I find that a very distinct history of syphilis was found in 36 out of the total 100 non-fatal cases. * * * *This fact that syphilis causes one-third of all cases of apoplexy has not, I think, been heretofore brought out, though I feel sure that the experience of neurologists will confirm it.*"

Folet reports a case of syphilitic hemiplegia occurring in a man aged 37, in whom the paralytic symptoms developed in three days, and who recovered in a year.

Boziere reports a similar case occurring in a man aged 30, in whom the symptoms developed suddenly, and who likewise recovered in a year.

Eisenlohr reports a case. Patient aged 30; had syphilis eleven years previous to an attack of rectal and vesical paralysis with paralysis of the right leg, paresis of the left, and greater reduction of cutaneous sensibility in the latter than the former. Improvement followed treatment, but later there was paresis of both legs, without ataxia. At the necropsy, the dura spinalis was found attached to the posterior portion of the cord by meningeal inflammation from the height of the tenth dorsal nerve to the cauda equina.

At the Congress of German Physicians, held in Vienna, 1894, Dr. Jolly reported a case of cerebral syphilis in which he was able to demonstrate by autopsy the dependency of word deafness and aphasia on a complete destruction of the parietal lobe, the two first temporal lobes, the angular gyrus, præcuneus and cuneus. The patient was unable to read his own name, or to write from dictation. The word deafness

Professor Jolly considers was due to the lesion in the temporal lobe, and the loss of speech possibly to the entire destruction of the auditory centre and areas.

Alfred Fournier, in a lecture, thus sums up his views on general paralysis in syphilitic patients: "Undoubtedly, general paralysis does occur in syphilitic subjects sometimes, but sometimes only, and in quite too exceptional a manner to warrant our regarding it as depending directly upon the evolution of the syphilitic morbid processes. It is very reasonable to suppose that a disease which affects the nervous system as profoundly as does syphilis, may be the determining cause in some cases. In syphilis itself the mental disturbances are not quite those of general paralysis; they may, indeed, present all varieties of excitement, violence, depression, or dementia, but they do not follow any special type, as do those of general paralysis. The condition of self-satisfaction of unfortunate subjects of general paralysis, who imagine themselves kings, prophets, great artists, who revel in fancied wealth, and propose every day fresh schemes, magnificent in the extravagance and boundlessness of their scope, all that makes up the common description of their delirium, is absent, or, at least, only exceptionally present in syphilis, and when present the extravagance is tame and humble in comparison. Tremor may be present in syphilis, but is only occasional; that of the tongue especially is very rare, while the tremor of the upper lip, so frequent in general paralysis, is perhaps never present—at least Professor Fournier has never seen it. Above all, the tremor lacks the constant, fibrillary, vermicular character of that of general paralysis. These differences are not merely of degree, but definite, and more easily recognized clinically than described by words.

"Paralysis and paresis of all kinds are common in syphilis, and correspond to what is ordinarily described by these terms; whereas in general paralysis it is more a want of co-ordination, and defect of precision, than abolition of mus-

cular power. Again, in syphilis, there is excessive frequency of partial paralysis affecting a special predilection for certain parts; for example, the muscles of the eye-ball, a peculiarity which is not found in general paralysis. Hemiplegia, transient or permanent, is often one of the earliest phenomena of cerebral syphilis, and of great frequency in some period of the disease. Finally, in syphilis, motor phenomena, apoplectic attacks, etc., commence the affection; in general paralysis, intellectual and moral disturbances prelude the symptoms of cerebral disorganization, while similar disturbances mark the course of the two diseases, syphilis being irregular, variable in its progress, in the succession of phenomena, and its duration; general paralysis, on the other hand, is regular, and of definite duration. The comparison of the general state of the patients in the two diseases gives not less striking distinctions; in syphilis, cachexia; in general paralysis, maintenance of nutrition, even *embonpoint*, up to the very last.

“Finally, syphilis may be regarded as at least possibly curable, gloomy as is the result in most cases, yet differing even in this from the other absolutely incurable malady.”

In 1886 I was the physician to a family whose adopted son was of rather unusual mixed nationalities. The father of the boy was a Chinaman, and his mother was born in Ireland. Their union was sanctioned by the church. In appearance he resembled the father, looking like an out-and-out Mongolian. At that time he was what might be called an interesting child; was effeminate in appearance and manners. He was devoted to his Sunday-school, and naturally he was a universal favorite with all good people. He was then about fourteen years old. In about a year he commenced to grow rapidly, and I noticed a peculiar shambling gait. He was knock-kneed. About this time he commenced to have persisted “tinnitus aurium,” and he was treated by two of our most eminent aurists. I placed him on a “mixed treatment,” with the effect of stopping “the

tic." I ascertained afterwards from the former family physician, who lives in South Carolina, that prior to the birth of the subject of this history, he had attended the father with the worst case of syphilis he had ever seen. The boy very gradually, almost imperceptibly, failed from day to day. I noticed a change in his naturally refined feelings. He became a victim of almost constant self-abuse. There was no aphasia. He would at times lose control of his sphincters. At this time his voice began to change, and he passed from childhood to young manhood. The bland and childlike countenance vanished, and he became a drivelling idiot. The Sunday-school instruction faded from his mind, and for hours at a time he would repeat certain profane words. He would at times appear to be dying, and I or some other physician would be called, but he would rally, and live on for months. In one of these attacks he was seen by Dr. Godding. In the summer of 1889 I met Dr. Godding in consultation in another case, and he expressed astonishment that the patient should have lived so long, and I promised to inform him when the end came, so that he could ask Dr. Blackburn to make a post-mortem.

The end came the last of December; Dr. Blackburn made the autopsy. There were present Drs. Edes, Kerr, and myself. I did not expect to publish this case, and took no notes, and will have to trust to memory, regretting that I cannot more fully give the post-mortem appearances. I had diagnosed extensive ramollissement. There was considerable shrinkings of the brain, and great oedema, and opacity of the pia-mater, and arachnoid. The convolutions were abnormal, and there was extensive softening.

On the 11th of December, 1894, I was consulted by Mr. ———, aged forty-two years, who stated that for many months he had had persistent headaches, occurring at night. He had consulted many physicians, who had treated him for neuralgia of malarial origin. The treatment, he said, making his condition worse. I obtained the following his-

tory : Eight years ago he had had a suspicious sore on the prepuce. At first his physicians were in doubt whether the sore was the initial lesion of syphilis or not. Subsequent syphiloderms, however, put at rest the question of diagnosis. He was placed under mercurials, and in a few months he was pronounced cured.

For eight years he had taken no treatment, and, as a rule, enjoyed good health. I gave an R containing hydrarg. bichlorid. and iodide of potassium, which, he stated, relieved the headache. On the evening of the 22d he appeared bright and cheerful. On the next evening he called, and said that he had not taken the medicine, and that he was not feeling well. While he was standing up about to leave, he said he felt exactly as if some one had struck him a violent blow on the back of the head. He sank to the floor, and it was with considerable difficulty I lifted him to my sofa. In half an hour he was able to get up, and he passed some urine. I examined it and found no albumen or sugar; specific gravity normal. I took him home in a carriage and placed him in bed, and applied oleate of mercury (10 per cent.) over his bald head and the nape of his neck. There was no elevation of temperature; pulse 72—full and regular. I commenced giving him fifteen grains (saturated solution) of iodide of potassium every three hours. The next day he complained of thickness of speech, and a sense of numbness on the right side. I gradually increased the iodide until he was taking 35 grains every three hours. There was no gastric disturbance. After a time there was slight coryza, and I commenced decreasing the dose until he was taking ʒj. every three hours. Patient daily improved in strength; headache disappeared. On January 26th I prescribed the following :

R. Hydrarg. bin-iodidi grs. ij
 Ammonii iodidi ʒij
 Potass. iodidi ʒvj
 Tinc. gentian comp. f. ʒiv

M. Sig.—Teaspoonful in water three times a day, after meals.

Patient would go out walking or driving every day. On January 28th he went to New York city, and I gave him a letter to Dr. R. W. Taylor, who stands, as you all know, so pre-eminent in our profession. I gave a favorable prognosis in this case.

On the first of February I received a letter from Dr. Taylor, which contains the following sentence, which gave me supreme satisfaction: "Your diagnosis, prognosis and treatment are all correct. I think, with you, that the patient can be cured, provided he follows treatment repeatedly. He undoubtedly has had endarteritis of syphilitic origin."

1750 *M Street, N. W.*

SYPHILIS OF THE VITAL ORGANS.*

By HENRY ALFRED ROBBINS, M. D.,
WASHINGTON, D. C.

EX-PRES. WASHINGTON SOCIETY OF MICROSCOPISTS; LATELY CLINICAL PROFESSOR OF
DERMATOLOGY AND SYPHILOLOGY, MEDICAL DEPARTMENT OF UNIVERSITY OF
GEORGETOWN; DIRECTOR OF THE DERMATOLOGICAL CLINIC AT THE
SOUTH WASHINGTON FREE DISPENSARY.

[Reprinted from the VIRGINIA MEDICAL SEMI-MONTHLY, MAY 8TH, 1896.]

The grave-digger in "Hamlet" says, in answer to the question how long a man will lie in the earth ere he rot, that he will last for eight or nine years,

"if he be not rotten before he die, as we have many pocky corsers nowadays, that will scarce hold the laying in."

According to the last report of the Register General of England, *eleven thousand and ninety males* died of syphilis in Great Britain in 1893. These occurred in eleemosynary institutions.

The *unreported* cases and the victims of *undetected* syphilis—where death was attributed to other diseases—would undoubtedly have quadrupled this number.

On the evening of the 27th of February, 1895, I had the honor of portraying to you the ravages caused by syphilis, when it attacked the brain and its membranes. Some of the material then used was derived from a lecture entitled "Organic Syphilis," which I had prepared for a class of medical students, and which appeared in the *Virginia Medical Monthly* of July, 1893 (*not August*, 1894). A portion of what I have prepared for this evening is derived from the same source.

SYPHILIS OF HEART AND ARTERIES.

Virchow describes syphilitic growths in the substance of the heart, and refers to those recorded by Ricord and Lebert.

* Read before the Medical Society of the District of Columbia, February 26th, 1896.

Ricord, in his Atlas, calls them "Syphilitic muscular nodes in the substance of the heart." They were found in the substance of the ventricles, and consisted of firm, cheese-like masses. There was a history of chancres and ulcerated tubercles of the skin. Lebert reports that gummata were seen at a comparatively early stage of development in his case, and were found in the wall of the right ventricle. There were tubercles of the skin, of the subcutaneous tissue, genital organs, and bones of the skull.

In Virchow's case there were syphilitic gummata in the testicles.

In the Museum of the British Army, Medical Department at Netley, there are two preparations which show such gummata in the substance of the heart. "One occurred in the case of a soldier, twenty-four years of age, under treatment for venereal ulcers, of nine months' duration, in various parts of the body. He had lost his palate, and eventually sank from exhaustion, with symptoms of phthisis. Sections of the muscular substance of the heart showed several isolated deposits in its substance and beneath its serous covering, and isolated portions of the lungs were converted into a substance of the consistence of cheese."

A few weeks ago, I visited the U. S. Army Medical Museum, and Dr. D. S. Lamb showed me a pathological specimen of a heart in which a syphilitic gumma was imbedded in the wall of the left ventricle. This specimen was exhibited in Baltimore, at the Johns Hopkins University, and its nature verified by the pathologists there.

For the clinical record, Dr. Lamb referred me to Health Officer W. C. Woodward, M. D., as the specimen was obtained from him when he was serving as coroner of the District. Dr. Woodward most kindly sent me the following report: "The patient came under my observation after death. The history was vague. Colored, male, thirty-three years old, a native of Virginia; was found dying in bed about five o'clock one morning by his wife, who had been sleeping by his side. He had complained for some time of

shortness of breath, and is said to have had night-sweats just previous to his death. There was, further, a history of continued ill health, not borne out by the condition of the body, attributed by his family to a hernia. There was no external evidence and no history of syphilis. Deceased was a huckster by occupation."

At a recent meeting of the Clinical Society of London, Dr. Duckworth (*British Medical Journal*, No. 1816, p. 974) reported the case of a strongly-built man, 35 years old, who, while walking in the street carrying his little boy, suddenly fell down and expired. Only a meagre antecedent history was obtained, but there was evidence of old syphilitic disease on the tongue and on the glans penis. A small gumma was found in the left lung. The heart weighed twenty-two ounces, and was bound by firm adhesions to the pericardium, both at the apex and the base. The ventricles were hypertrophied and dilated; the valves were normal. In the wall of the left ventricle, above the apex, was a round depression, nearly an inch in diameter, and covered by long adhesions. This was due to a thinning of the wall, with much endocardial thickening. A large aneurismal pouch was found behind the posterior cusp of the mitral valve. This appeared from without as a tumor growing from the base of the heart, and completely covering the left auricle. Its walls were half an inch thick, and the pericardium was closely adherent over it. On section the muscle was replaced by tough, fibrous tissue, with foci of gelatinous matter. The endocardium was greatly thickened and fibrous. Microscopic examination proved the formation to be gummatous in nature, with patches of caseation. The smaller vessels showed signs of endarteritis. These appearances were taken to indicate a recent gummatous growth at the base of the left ventricle, and a similar but older one near the apex of that cavity.

Investigation showed that in 14 similar cases death occurred quite suddenly in eight. But one case in the whole number was in a woman. The mean age of all the patients was 32 years. Many of the cases seemed to have been de-

void of urgent symptoms. In some there had been pericardial pain. The valves were not usually involved, and hence murmurs were not to be heard. The ventricles and their septa were the common sites of the growth. The tendency to fatal and sudden syncope was probably attributable in part to endarteritis affecting the coronary vessels, and possibly to the formation of embolisms in the branches of the coronary arteries, as a result of the dislodgment of fragments from the interior of aneurisms.

During a recent meeting of the Montreal Medico-Chirurgical Society, Dr. Finley presented the report of a case of syphilitic gummata of the heart and liver, and exhibited the pathological specimens showing the characteristic lesions.

At a late meeting of the Charité Aeczte of Berlin, Dr. Israel exhibited pathological specimens, and gave the following clinical history :

During life the patient, aged 47, had presented the appearance of hepatic cirrhosis. The pulse, 136, was small and irregular at first, but improved under digitalis. A systolic murmur was heard in the left, second and third intercostal spaces, with an accentuated second sound. There was no clinical evidence of syphilis. Eight days after admission, there was a profuse and fatal hæmorrhage from the stomach. The autopsy showed the heart to be hypertrophied, but only slightly dilated. No circulatory obstruction could be proved at the mitral orifice. Islets of fibrous tissue were present at the base of the papillary muscles, and the muscles themselves had undergone fibrous changes. Fine strands of fibrous tissue were seen in the slightly brown cardiac muscular tissue. The dilated left auricle presented peculiar appearances. The wall was rigid, with only the remains of a few yellowish-brown muscular fibres. The auricular appendix was greatly shrunken. Very irregular and easily detached excrescences were found in the inner wall of the auricle, and were especially well marked on the upper surface of the mitral valve segment. The gummatous formation in the heart muscle could only be due to syphilis. In the liver fibrous

changes with the remains of gummata were found. There was induration of the uterus with chronic endometritis, also of syphilitic origin.

On January 9th, 1893, John S. Bristow, M. D., LL. D., F. R. S., of London, read an article on Syphilitic Affections of the Nervous System before the Medical Society of London. I take the liberty of quoting two of his cases, illustrative of *syphilitic arterial disease* :

"The first of these was brought before the Pathological Society by Dr. Walter Edmonds on May 3, 1892. The patient was a man, aged 36, who came under Sir Wm. Mac-Connar's care on account of his aneurism on the right side of the neck, which had been rapidly increasing in size. He had, a few days before admission, been seized with a sudden attack of faintness, and after admission the mere handling of the tumor frequently brought on similar attacks. Owing to this circumstance, the belief that his arteries were extensively diseased (for no trace of pulsation could be felt in any of the arteries of either upper extremity, and there was a loud basic systolic murmur), and to the fact also that the patient was exceedingly ill, it was decided not to attempt any operative procedure. The patient had well marked syphilis twelve years previously. He died comatose twelve days after admission. The heart was large, and the pericardium adherent by easily broken down adhesions. The valves were healthy. A gumma about two inches in diameter projected from the groove between the right auricular appendage and the pulmonary artery. The whole of the thoracic aorta, including the arch, was enormously thickened, all the coats being involved, but the outer coat much more than either of the others. In places they were collectively more than eight times as thick as natural. The thickening extended along the innominate and right subclavian, the latter of which would scarcely admit of the passage of a bullet probe. The right common carotid was healthy, but the right internal had springing from it near its origin a globular aneurism about two inches and a half in diameter. The left common carotid was diseased, and only admitted a bullet probe; and the left subclavian, about an inch from the aorta, ended in an impervious fibrous cord. The cerebral and abdominal arteries were all healthy, and no other visceral syphilitic lesion was discovered.

"The second case was exhibited before the same society and on the same evening by Dr. Herbert Hawkins. It was that of a girl, aged 11, who was admitted into St. Thomas' Hospital suffering, it was supposed, from acute nephritis. After experiencing one or two short attacks of illness, probably due to infarction of the lungs, she was observed on February 7th to have swollen and cold legs, and, a few days later, swelling of the face. She was admitted on the 20th, being at this time extremely ill. She had general dropsy, was passing very little urine, which contained a small quantity of albumen, but no casts, and there was evidence of pulmonary congestion. Subsequently she passed a little blood on one occasion with her urine, which continued to be for a time very scanty, but, during the last four days of her life, it became fairly abundant, and ceased to be albuminous; the lower part of her lungs became solid; her pulse of high tension; she presented the Cheyne Stokes breathing, and died (apparently from uræmic poisoning) on March 22d. At the post-mortem examination, gross disease was found in nearly all the arteries of the body. The first part of the aorta was studded with gray translucent spots and patches, from the size of a split pea to that of a half crown; and for a length of three inches, immediately above the bifurcation, the thickening was so great that that channel barely admitted a bullet probe. Similar patches were observed in the common carotids and subelavians, in the left internal carotid as it entered the cranial cavity, and in the right internal carotid involving the origin of the middle cerebral. There was similar disease throughout the pulmonary arterial system. The renal arteries towards their entrance into the kidneys were completely obstructed by clots, which were old and white at the periphery, but red and comparatively recent centrally. There was an old infarct in the kidney, but neither organ showed any evidence of nephritis. The liver presented a patch of peritonitic thickening, and was rather large. The spleen was large and firm, and its capsule thick and covered by old adhesions. The lower and back parts of both lungs were consolidated and contained large infarcts. There was hæmorrhage into each lateral lobe of the cerebellum, the clot in each case being the size of a hazel nut.

"There can be no doubt, however, that the lesions in this case were the result of congenital syphilis."

I find in *London Lancet* (January 1, 1887), the following:

"At a late meeting of the London Pathological Society,

Dr. W. Pasteur showed a specimen of syphilis of heart from a woman, aged 30, who was taken to Middlesex Hospital *in articulo mortis*. She was probably a prostitute. None of the ordinary signs of syphilis were visible except in the heart. The liver had a peculiar marbled appearance. There was some recent lymph on the surface of the left ventricle, which was hypertrophied and dilated. Grayish opaque patches of varying size and distribution were seen in the wall of the ventricle and septum. At least one-half of the ventricle was diseased. The patches were ill-defined and translucent at the edges. There were milky looking patches on the endocardium. Microscopical sections showed infiltration of corpuscular growth, which was very vascular at the margin; the nuclei were spherical and distended. In some of the vessels of the heart doubtful evidences of periarteritis were to be seen, and possible also of endocarditis. The liver showed numerous accumulations of small round cells, like that met with in some forms of interstitial hepatitis of congenital syphilis."

At the Berlin Medical Society, Dr. A. Fraenkel recently demonstrated a specimen of cardiac syphilis from a woman, 36 years of age. When first seen last year she had aortic regurgitation, and suffered from frequent headaches, which were occasionally associated with fainting attacks. The heart disease was supposed to be consequent on acute rheumatism. The husband was syphilitic and the woman herself had suffered from swellings on the head, which had ulcerated and left scars. She improved at first and left the hospital, but was readmitted this year with severe attacks of angina pectoris, in one of which she died. At the necropsy the left coronary artery was found quite permeable, but the orifice of the right coronary was completely obliterated by a process of arterio-sclerosis (which was in excess of the patient's years), and its proper position could only be determined by probing backward along the lumen of the artery. There was a gummatous tumor, four and one-half centimeters long, in the septum ventriculorum, and Fraenkel thinks this shows that the arterial changes were really of syphilitic nature. The arterio-sclerotic changes in the aorta reached down to the bifurcation. Fraenkel, moreover, re-

marks on the part played by syphilis in the etiology of aneurisms. Walsh thought that sixty per cent. of true aneurisms were due to syphilis; others think still more. Fraenkel himself, during the last four years, has seen nineteen cases of aneurism of the thoracic aorta in which there were necropsies. Three cases were in women, sixteen in men. Of the nineteen patients, nine—that is, forty-seven per cent.—had had syphilis, and these were all under fifty years of age. The case illustrates the relation of precocious arterio-sclerosis and syphilis.

“Mraick (*Med. Chir. Centralblatt*, June 21, 1895) refers to authors, and states that, especially just preceding the roseola, in the second stage of syphilis, disturbance of the heart's action is not uncommon. He quotes Fournier to the effect that these troubles are functional, and not dependent upon distinct lesions of the heart itself, and that they are distinctly transitory by nature, disappearing without leaving a trace, occurring much more frequently in women, and commonly associated with nervous disturbances. The later forms of heart syphilis appear, however, as distinct pathological changes. The symptoms of the affection are those of degeneration of heart muscle or interference with the valves, whatever is the cause of these pathological conditions.

“Semmola holds as pathognomonic a persistent arrhythmia, either existing alone or accompanied by tachycardia, respiratory troubles coming and going, resistance to all ordinary methods of treatment, and a history of syphilis. Through syphilitic stenosis of the coronary artery the symptoms of angina pectoris may be caused. Exceptionally, murmurs are developed. The course of syphilis of the heart is extremely slow and insidious. There is rarely any acute process, such as a softening of a gumma, but rather a slow transformation in the fibrous tissue. Judging from reported cases, the prognosis is extremely bad, death coming suddenly, and often in the midst of apparent perfect health. In sixty-three cases collected by the author this suddenly occurred in one-third of the number. Jullien and Mauriac stated that this end is observed in fifty per cent. of cases. Death comes after a heavy meal, or from drinking or straining. Often the patients are found dead in bed. Many cases perish in coma from heart failure.”

Dr. H. P. Loomis, of New York city, published in the *American Journal of Medical Sciences*, October, 1895, a very able and instructive article, giving in detail his services as curator for ten years for Bellevue Hospital. *Fifteen hundred or more autopsies came under his personal observation, where certain pathological changes, "which were unquestionably of syphilitic origin, yet which failed in spite of marked symptoms to be diagnosed during life as manifestations of syphilis."*

PULMONARY SYPHILIS.

Lammonier nearly a century ago described the existence of phthisis pulmonalis of a syphilitic character. Then followed a long series of years when syphilis was not recognized as attacking the internal organs, probably owing to the teachings of John Hunter and Sir Astley Cooper, who did not believe in any visceral complications of syphilis.

In 1826, Laennec and Vandal recognized and described syphilis of the lungs, identical in its symptoms to those of phthisis pulmonalis. Van der Kolk insisted that syphilitic subjects died presenting "phthisical appearances, with ulceration of the lungs, situated most frequently in the middle lobe, but without tubercle." Ricord and Lancereaux and Alfred Fournier have, by pathological anatomy, proved that symptoms of phthisis are not only possible, but very frequently the same as those produced by syphilis.

SYPHILITIC BRONCHO-PNEUMONIA.

Drs. Balzer and Grandhomme have recently made several necropsies of syphilitic still-born infants, and the results of their examinations prove that syphilitic lesions, which are caused by microbes, like other inflammations, do not appear to preserve any specific character in their evolutions. With regard to the lungs, syphilitic pneumonia may be classed with broncho-pneumonia, in the same degree as secondary pneumonia in acute infectious diseases, such as measles, or in chronic affections, like tuberculosis. Syphilis in the fœtus assumes the different forms of broncho-pneu-

monia and other lesions, according to its violence and the degree of its chronic stage. The authors classify these forms of broncho-pneumonia, including pulmonary congestion, and lesions which are not apparent on microscopic examination. 2. Broncho-pneumonia or agglomerated nuclei disposed in a vertical band at the posterior portion of the lungs. These forms correspond, with regard to lesions, to subacute forms of broncho-pneumonia of other infectious diseases, and invariably assume the following type. 3. Broncho-pneumonia, with white hepatization, without dilatation of the bronchi, corresponding to the hepatization of other forms of broncho-pneumonia. It may lead to fibro-caseous or gummy degeneration. 4. Broncho-pneumonia, accompanied by dilatation of the bronchi.

It may be said that pulmonary syphilis is identical at different ages.

At a meeting of the Moscow Dermatological Society, Pospelow and Kontrim (*Monatsh. für prakt. Dermatologie*, 1895, No. 12, p. 644) each reported two cases of syphilitic pneumonia that yielded to treatment with mercurials. Hæmoptysis occurred in three of the cases, and fever with sweating was present in two. The lesion was localized to the apices. In one of the cases, tubercle bacilli were found in the sputum, and the process was believed to be tuberculous. Treatment with mercurial inunctions and sulphur baths, with a residence in Egypt, was followed by general improvement and disappearance of fever, cough, and expectoration. The patient had been well for three years at the time of the report. In this case it is believed that the tuberculous affection was implanted upon the syphilitic pneumonia, disappearing with the latter.

SYPHILITIC PLEURISY.

In the *Presse Medicale*, of the 20th ultimo, M. Chantemesse publishes a clinical lecture on the above rare complication of constitutional syphilis. The subjects of the lecture were two men who presented the usual stigmata of syph-

ilis in the eruptive stage. In both there were discovered the physical signs of pleurisy with effusion, and in one aspiration with a hypodermic syringe yielded a quantity of straw-colored serum. Both had râles, due probably to an eruption of roseola on the bronchial mucous membrane. M. Chantemesse had succeeded in collecting twelve similar observations of syphilitic pleurisy. Most of them were cases of dry pleurisy, but in either case the prognosis is favorable, resolution and absorption being the rule under specific treatment. M. Chantemesse treated his patients with intravenous injections of corrosive sublimate; he nevertheless does not recommend this method, but would prefer intramuscular injections of the red oxide of mercury dissolved in sterilized olive oil. He says that he has never noticed any stomatitis during a treatment of several months, consisting of daily doses of four or eight milligrammes of the salt dissolved in one or two cubic centimetres of the oil. The specific character of the pleurisy is plain to M. Chantemesse from the following peculiarities: Its bilaterality, the small amount of effusion, its concomitance with the secondary eruption, its complete disappearance without leaving any traces, and its prompt cure by mercury. The lecturer is inclined to believe that the so-called secondary fever of syphilis may be in many instances explained by the existence of this kind of pleurisy, which in the presence of indubitable signs of lues venerea is not suspected or sought for. In one-half of the cases bronchitis is present as well, this complication being probably due to the outbreak of a syphilide on the bronchial mucous membrane.

Syphilitic lesions in the lungs have been fully described by many authors. The patient may have all the symptoms of tuberculosis, and yet there may be no tubercle existing in the lung. There is great dyspnoea and periosteal tenderness, and the bodily temperature is not generally increased.

Dr. Rendu, at a recent clinical lecture, presented an old woman who had for a long time been emaciated and cachectic, but without fever. The symptoms were ill-defined, some

pain, stiffness of the limbs, without marked weakness or paræsthesiæ, dyspnœa on exertion, and for a short time a dry cough without expectoration. The respiratory and auscultatory phenomena were found normal, anteriorly, but behind there was dullness over the right apex, with roughened prolonged expiration. There was a loud, rough, systolic murmur, together with a softer and more superficial one, but no symptom of cardiac insufficiency. The arteries were apparently healthy, the liver normal in size, and there was no albuminuria. There was a diffuse and characteristic syphilitic melanoderma, and iritis of two years standing, nocturnal bone pains and headache. Her only previous illness had been measles. It was pointed out that against tuberculosis was (1) the long duration, (2) the absence of expectoration, of râles, and of concomitant symptoms. Syphilis does not usually attack the apices, although cases of this occurrence are recorded. Syphilis and tuberculosis may occur in association, and tuberculosis may attack a lung previously syphilitic. From the absence of a history of acute pneumonia an indurating pneumonia could here be excluded. The attack of measles was not considered adequate cause. As there were no other etiological factors, the changes in the heart and lungs were probably syphilitic. Great improvement followed the exhibition of mercury and iodide of potassium.

The following typical case occurred in the practice of Professor Alfred Fournier at the *Hospital St. Louis, Paris*:

The patient was admitted on March 1, 1884. He had been wasting for two months, as he said, and lately he had become so easily fatigued that he was unable to work. He was 39 years old. He had only had a cough for a few days, and had not suffered from night-sweats or hæmoptysis. After admission, however, he spat a blood-stained, mucopurulent fluid. At the left apex there were all the signs of a large and advanced cavity—cavernous breathing, gurgling, and cracked-pot sound on percussion. Over the right lung the breathing was somewhat blowing in character, with sub-

crepitant râles. Fournier diagnosed tuberculosis of both lungs, but most advanced in the left. The left tibia was enlarged and irregular, and on the same were two gummy ulcers.

The discovery of these signs led to the administration of iodide of potassium in a daily dose of sixty grains. After two months' treatment the signs of lung mischief had almost disappeared and the nodes had considerably diminished in size. Eleven months later the patient was again seen. His general health was then excellent, and the chest lesions appeared to be completely cured. The patient, however, had only continued the iodide for a month after his discharge, and ulceration had reappeared in the left leg.

Attention is directed to the fact that there were no physical chest signs in this case by which the diagnosis between tubercle and syphilis could be made. It was only by effects of treatment that the true nature of the affection became evident.

Dr. Brambilla has reported the following case: "In a hospital a phthisical patient occupied the adjoining bed to a syphilitic. The first was extremely ill, and there was little hope of his recovery. Through a mistake of the apothecary, the mercury which was ordered for the syphilitic patient was given to the one with phthisis. He soon recovered his former health and vigor and left the hospital."

Dr. R. Abrahams, of New York city (*Medical Record*, December 28, 1895), reports the case of a man, aged 35, who was far advanced in pulmonary tuberculosis, having had severe hæmorrhages. The sputa contained abundant bacilli. "Physical examination disclosed flatness above and below the right clavicle; subcrepitant and mucous râles and bronchial breathing. Mucous râles were heard all over the chest. Creosote and the most improved treatment was employed. This man acquired syphilis, and eight weeks after inoculation he was seized with a chill, then another chill, which was followed by the appearance of roseola. "This systemic disturbance continued for five days; every day the

eruption became more and more pronounced and more and more diffused. At the end of this period the temperature fell to the normal; the eruption then extended almost over the entire body." The patient was then put under most rigorous anti-syphilitic treatment. Dr. Abrahams further states: "It is needless to mention that all the secondary symptoms, and the traces, left by the primary lesion vanished under this treatment. But what was more wonderful was, that, from the very start of the evolution of the secondary period, and all along, through this energetic specific treatment, all the signs of consumption, one by one disappeared. Night-sweats stopped; the evening fever abated; the cough and expectoration became insignificant; the appetite returned; the patient gained flesh and strength; and what is more, at the end of fifty days' treatment, a physical examination revealed no trace, absolutely none, of existing phthisis; the percussion note was normal instead of flat; the breathing was normal in place of bronchial; all râles were gone, the sputa failed to show bacilli, so that, so far as I could see, the man was cured of his tuberculosis. I kept him for a couple of months under observation. Occasionally he required a dose of iodide, but I could not see any need for treating anything but syphilis. The patient to-day is in his native land—Poland." Dr. Abrahams occasionally hears from his former patient, who appears to be enjoying the best of health, which has continued for five years.

Dr. F. W. Ross, of Elmira, N. Y., reports, in the *Medical Record* of February 15, 1896, a very interesting case of a young man who had all the rational and physical symptoms of pulmonary tuberculosis. Notwithstanding his debilitated condition, he acquired syphilis. The initial lesion was on the glans, followed in due time by roseola, etc. Under prompt and energetic anti-syphilitic treatment, every symptom of syphilis and *tuberculosis* vanished. Seven years later, he was enjoying perfect health.

Notwithstanding these very unique cases, I would not advise patients suffering from pulmonary tuberculosis to ac-

quire in one way or another syphilis. Dr. Landouzy believes that no infectious group of diseases is as formidable as the combination of syphilis and tuberculosis. "In weakening the system, it permits the development of the bacillus; and on the other hand, by the lesions of the pulmonary apparatus, it permits the inoculation of the tubercle bacillus."

SYPHILIS OF THE LIVER.

Dittrich and Gubler were the first to give an account or description of syphilitic deposits in the liver. Virchow described peri-hepatic lesions and simple gummy interstitial hepatitis. The former never occurs alone, but is generally associated with the latter. The hepatic substance atrophies, and the deposit contracting, is eventually absorbed, causing a cicatrix-like mark. The liver lesions are usually among the later symptoms of syphilis, and are well described by Virchow and Wilks. Dr. Teissier relates the case of a boy, fifteen years of age, who came under his care, suffering from ascites; there was also diarrhoea and a slight cough. The diagnosis was made of tuberculosis of the peritoneum, intestines, and lungs. Paracentesis was performed several times, and the child was put upon a tonic and diuretic treatment, but he sank rapidly and died. At the autopsy there were no tubercles discoverable in any of the organs or serous membranes. Of all the viscera, the liver alone showed any changes. It was rather small, and presented upon its surface yellow nodules, hard as a stone, and covered with a fibrous envelope. This latter sent out white fibrous prolongation, following the course of Glisson's capsule, and giving to the liver a lobulated appearance. Examination, both macroscopical and microscopical, showed the case to be syphilis of the liver, and this was further confirmed by the statement of the parents that the child had acquired "a disease" from his nurse.

SYPHILIS OF THE SPLEEN.

In former years, I passed several months in walking the wards of Guy's Hospital, and was present daily in the patho-

logical room, which was under the supervision of the late Dr. Moxon, whose sad death occurred a few years ago. Dr. Moxon found syphilis deposits in the spleen, consisting of sulphur-yellow nodules of the size of peas, plentifully scattered, deep-seated, and fatty in their centre.

Dr. Haslund, of Copenhagen (in the *Vierteljahr für Dermatologie und Syphilographie*, Heft. 2, 1882), gives the post-mortem records of the Communal Hospital of Copenhagen for a period of fifteen years (1865-80). Among these he found 154 cases of children who died of inherited syphilis. In ninety-six, the spleen was healthy. In the remaining fifty-eight cases the spleen was diseased, the change being due to hyperplasia in fifty-five; in fourteen of these, the consistence of the tissue was normal; in thirty-one, the organ was harder, and in ten, softer than natural. Further, one case of infarct was noted, one of fibrinous deposit on the serous surface, and one in which there was thickening of the capsule. In none of these three is there mention of alteration in size or consistence. Among these fifty-five cases of hyperplasia, fibrinous deposits on the surface of the spleen were noticed nineteen times, scattered patches of thickening of the capsule four times, and adhesions to neighboring parts once. Finally, in three cases, there were miliary tubercles in the spleen, associated with tuberculosis of the other organs. As regards the significance of these changes, the author is of the opinion that the simple hyperplasia must be considered to be in direct relation with the general disturbance of nutrition caused by syphilis; but whether it be a cause or a consequence of the cachexia, must remain doubtful, until the functions of the spleen are better understood. The other changes noted are considered to be directly due to syphilis. Among the 154 cases, there was not one of amyloid degeneration, and in only one were gum-mata mentioned in the report.

The author also examined the post-mortem records of forty-four adults who died during the course of syphilis in the department of the hospital during the same series of

years. In three of these, there was amyloid degeneration of the spleen. This change, Dr. Haslund thinks, is always dependent upon chronic suppuration either in the superficial tissues, in the bones, or in the internal organs. Of the three cases just mentioned, there was old necrosis of the scapula and clavicle, and suppurative pyelonephritis with calculi in the pelvis of the kidney and left ureter in the third. Among the forty-four cases, there was no instance of gummata. In ten, the spleen was healthy; in twenty-seven, there was more or less hyperplasia, the organ being softer than natural in eleven, and firmer than natural in sixteen; scattered thickenings of the capsule were noticed in two cases, and adhesions to the surrounding parts in four cases.

Gummata have been found in the pancreas by Dr. Walton Moxon, who was an early worker in the field of visceral syphilis, and who reported his discoveries in Guy's Hospital Reports nearly twenty-five years ago.

RENAL SYPHILIS.

Syphilis in any of its stages may affect the kidneys. The best essay on the subject that I have found is an inaugural thesis written by Dr. Negel, which was quoted at length in the *Journal of Cutaneous and Venereal Diseases*, May, 1884.

The subject of specific nephritis was brought up for discussion before the London Clinical Society some years ago (reported in the *Annals de Dermatologie et de Syphilographie*, April, 1881). At a meeting of this body, M. Barthelemy reported several cases of hereditary syphilis, in which, among other affected organs, the kidneys have been involved, being the seat of parenchymatous nephritis.

Referring to such patients, Mr. Hutchinson stated that when death occurred as a consequence of syphilis, the fatal result was directly due to the nephritis. Dr. Coupland was convinced that patients who had been suffering for a long time from syphilis acquired a true predisposition for parenchymatous nephritis, and were liable to death from this condition. As a result of his personal researches, M. Barthel-

emy offers the following: Nephritic lesions are among the complications of all stages of syphilis, even of acquired disease. Such nephritic complications are always grave. Nevertheless they are curable, not only when they occur in adults as a result of acquired syphilis, but also in childhood affected with the hereditary disease. Together with other specific lesions, they have this characteristic in common: their gravity is in proportion to the age of the patient's syphilis, and the period of time which has elapsed before specific treatment was begun. In children affected with hereditary syphilis, specific nephritis should always be taken into consideration, when the patients are subjected to accidents for which nephritis may be held accountable. When a physician meets nephritis in an adult he would do well to think of the possible origin of the renal difficulty *in view of the great number of cases of unsuspected syphilis.*

Dr. Hock showed at a meeting of the Medical Club (Vienna) an infant, the second child of a syphilitic mother, who eight weeks after its birth showed a syphilitic erythema, which disappeared under the influence of proto-iodide of mercury. Later the extremities and penis began to swell, and an examination of the urine showed albumen, hyaline casts, and white and red corpuscles. Other symptoms of syphilis disappeared under the use of iodide of potash.

In 1878, Dr. L. P. Yandall, of Louisville, Ky., reported (*Maryland Medical Journal*, May, 1878) a case of syphilitic albuminuria, which is of great interest. The patient was an intelligent German, 60 years of age, and was an inmate of the Louisville City Hospital, December 1st, 1873. "He was a subject of general dropsy, and on the card over his bed was written, 'albuminuria.' His pale, waxy-looking skin, puffy eyelids, constant indigestion, slight bronchitis, disturbed vision, hæmicrania, pain in the back, muscular debility, and frequent nocturnal micturition, all confirmed the diagnosis, and examination of the urine showed it to be excessively albuminous and abundant in tube-casts and renal debris.

"Deriving no comfort from treatment, and, indeed, growing gradually worse all the time, and having no hope of recovery, he begged to be allowed to desist from treatment, and the request was granted at the end of two weeks."

The patient's nose had the "saddle-shaped" appearance so often associated with tertiary syphilis, where the nasal bones have come away. This, with other indications of syphilis, decided the doctor to give the patient the therapeutic test. The doctor prescribed a scruple of the iodide of potassium, to be taken in skimmed milk or water, every three hours when awake—the doses to be increased ten grains each every day till iodism, gastric disturbance, or relief of symptoms should occur. He took, on several occasions, an ounce of the medicine daily, and never had any discomfort from it. Iron and bitter tonics were given at the same time. His improvement was marked at the end of a few days. The throat rapidly healed, his strength, appetite, and color returned, and the urine ceased to evince any sign of renal disease. In two months he was well."

My object in this paper has been to call your attention to the fact that syphilis as a cause for cardiac, pulmonary, hepatic, and renal diseases has been doubted, and even taught, by distinguished professors, not to exist.

Whenever I hear of a miraculous cure of Bright's disease, as a result of a certain notorious quack medicine which is known to contain a large per cent. of iodide of potassium, I think that a physician has gone astray in his diagnosis, and that the germ of the disease was of specific origin, giving rise to the train of symptoms identical with those of fatty degeneration of the kidneys.

1750 *M street, N. W.*